UNDERSTANDING **YOUR INSURANCE**

Guidance on how to review and compare different health insurance plans to find the right fit for you and your family's health care needs.

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BLEEDING & CLOTTING DISORDERS INSTITUTE
THE BLOOD EXPERTS

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OUR MISSION

The mission of the Bleeding & Clotting Disorders Institute is to provide integrated, family-oriented care, treatment and education for persons with bleeding, blood clotting and other blood disorders.

Our board-certified team of providers offers personalized, multidisciplinary medical care to promote the highest quality of life possible for our patients. By providing integrated care, we treat the whole person and their family - physically, mentally and emotionally. Our staff offers knowledge and support through all aspects of bleeding disorders and all life stages.

QUESTIONS TO CONSIDER WHEN RESEARCHING DIFFERENT PLANS

Selecting a health insurance plan can be a challenging and overwhelming process. Included in this toolkit, you'll find information to help you determine which health insurance plan is best for you. To help guide you through the process, towards the back of this toolkit (pages 10-15) you will find a glossary of commonly used health insurance terms and their meaning.

QUESTIONS TO ASK:

1. How much will my monthly (or annual) insurance premiums cost?
2. How much will my total out-of-pocket expenses cost? (medical copays, prescription copays, deductibles and coinsurance)
3. Will this plan cover all medical services for my family?
4. Are my physicians in-network? (primary care/specialists/pharmacy)
5. Are out-of-network benefits available? What would my cost be for using these benefits?
6. Does this plan have annual limits? If so, what are my maximum benefits?
7. Is Durable Medical Equipment (DME) covered? (crutches, braces, slings, etc.)
8. Am I covered if I need treatment when out of state?
9. What is the preferred hospital?

QUESTIONS SPECIFIC TO PATIENTS WITH BLEEDING DISORDERS

QUESTIONS TO ASK:

1. Is my clotting factor/medication covered? If so, is it covered under my medical benefits or my pharmacy benefits?
2. Does my medication require prior authorization?
3. Is my preferred specialty pharmacy in-network?
4. Is my Hemophilia Treatment Center (HTC) in-network?
5. Does the plan accept third party premium assistance?
6. Do I need a referral to see a specialist (hematologist)?
7. Are physical therapy services covered?

WHERE TO FIND THE ANSWERS TO THESE QUESTIONS WHEN LOOKING AT DIFFERENT PLANS?

Your Human Resource Representative, Insurance Agent or Marketplace Navigator should provide you with the following documents for insurance plans that are available for your review:

- Plans Summary of Benefits and Coverage
- Drug Formulary Lists (preferred drug list)
- Provider Network Directory

GETTING STARTED

To compare your current health insurance plan to other health insurance plans available to you, complete the included Health Insurance Comparison Worksheet to determine which option will best fit your needs. While comparing the plans, keep in mind what needs you currently have and what needs you expect to have within the next year. Pick the plan that best supports all these needs.

1

Complete the Health Insurance Comparison Worksheet with the benefits and costs from your current plan.

This will give you a baseline of what benefits you currently receive and how much you are currently paying for these benefits.

2

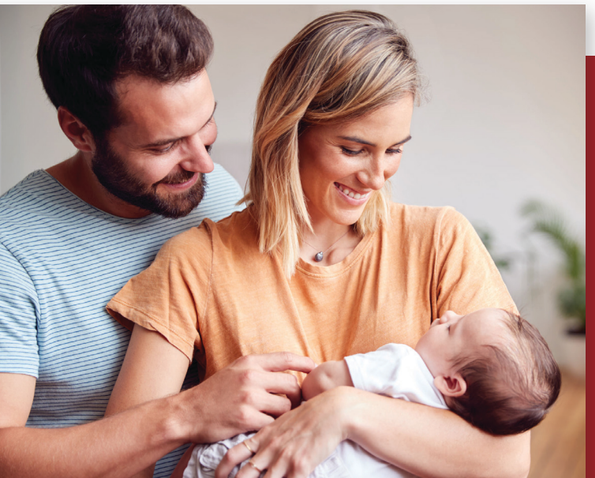
Complete the Health Insurance Comparison Worksheet using the benefits and costs from up to two additional plans available to you.

Use the plans' Summary of Benefits and Coverage document, Drug Formulary List and Provider Network Directory to help you understand the benefits and costs of each plan.

3

Review and compare your answers for each plan.

Summarize each plan's benefits and costs to make the best decision for you and your family's medical and pharmacy needs.



Keep in mind…Once you select a plan, you cannot switch until open enrollment next year or if you experience a qualifying life event like having a child or marriage.

COMPLETE THE HEALTH INSURANCE COMPARISON WORKSHEET

	CURRENT PLAN	OPTION #1	OPTION #2
PLAN NAME			
What type of plan is this? (circle one)	HMO, PPO, POS, EPO	HMO, PPO, POS, EPO	HMO, PPO, POS, EPO
Does your plan require you to choose a primary care physician (PCP)?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Is your current PCP in-network?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
EXPECTED COSTS			
Monthly Premium	$	$	$
In-Network Deductible For myself:	$	$	$
In-Network Deductible For my family:	$	$	$
Out-of-Network Deductible For myself:	$	$	$
Out-of-Network Deductible For my family:	$	$	$
What is your Coinsurance? (80/20, 70/30, etc.)	$	$	$
Annual Maximum Out-of-Pocket (separate in-network & out-of-network) For myself:	$	$	$
Annual Maximum Out-of-Pocket (separate in-network & out-of-network) For my family:	$	$	$

	CURRENT PLAN	OPTION #1	OPTION #2
OUTPATIENT SERVICES			
Physician Office Copay	$	$	$
Specialist Copay	$	$	$
Emergency Room	$	$	$
Surgery	$	$	$
Laboratory Services	$	$	$
INPATIENT SERVICES			
Preferred Hospital(s)			
Physician & Surgeon Services	$	$	$
Semi-Private Room & Board	$	$	$
All Drugs & Medications	$	$	$
PREVENTIVE SERVICES			
Physical Exam	$	$	$
Routine Pediatric Care	$	$	$
Immunizations	$	$	$
MATERNITY CARE			
Prenatal & Postnatal Care (per visit)	$	$	$
Hospital Services (mother & child)	$	$	$

	CURRENT PLAN	OPTION #1	OPTION #2
PHARMACY BENEFITS			
Are my current medications covered?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Yearly Deductible (pharmacy)	$	$	$
Copay Tier 1			
Copay Tier 2			
Copay Tier 3			
Copay Tier 4 (specialty drugs)			
Is clotting factor covered under the pharmacy or medical benefit?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Preferred Pharmacy Choice			
Prior Authorization Required	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Does the plan use an alternate funding model?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
OTHER			
Number of Physical Therapy Visits Allowed			
Is Durable Medical Equipment covered?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
MENTAL HEALTH			
Number of Inpatient Visits Allowed			
Number of Outpatient Visits Allowed			
SUBSTANCE ABUSE			
Number of Inpatient Visits Allowed			
Number of Outpatient Visits Allowed			

A GLOSSARY OF COMMON HEALTH INSURANCE TERMS

In this section, you will find a listing of common health insurance terms used when reviewing health insurance plans.

Throughout this toolkit, you will see these terms being used. Reference this glossary as a guide for determining the meaning of commonly used terms as you navigate your health insurance plans.

Accumulator
Refers to the running total amount of money you have paid towards your out-of-pocket maximum for covered services. This includes the amount you paid towards your deductible, copays and coinsurance, but not your monthly premium payments.

Accumulator Adjuster Programs
A program used by pharmacy benefit managers (PBMs) which allows them to identify when a manufacturer copay card has been used and prohibits it from counting towards your deductible or out-of-pocket maximum.

Affordable Care Act
Also known as the Patient Protection and Affordable Care Act (PPACA), health care reform (HCR) and Obamacare. It is the comprehensive healthcare reform law enacted in March of 2010. The law was enacted in 2 parts: PPACA law signed on March 23, 2010 and the Health Care and Education Reconciliation Act signed on March 30, 2010. Affordable Care Act refers to the final, amended version of the law.

Alternate Funding Model
Insurance plans that allow employers new ways to pay for health services, manage costs and help employees get more value from their benefits.

Annual Limit
A cap of the benefits your insurance company will pay in a year while you're enrolled in a health insurance plan. Annual caps are sometimes placed on services such as prescription and hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits for a particular service. After the annual limit is reached, you must pay all associated healthcare costs for the remainder of the year.

Benefits
The healthcare items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents.

Claim
A request for payment that you or your healthcare provider submits to your health insurer after you receive a covered service or item.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law that may allow you to temporarily keep health coverage if your employment ends or you are no longer eligible for coverage, lose coverage as a dependent of the covered employee or if there is another qualifying event. COBRA requires you to pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance
A form of medical cost sharing that a health insurance plan requires an insured person to pay. Usually it is a percentage (rather than a set dollar amount) of medical expenses after deductible amount, if any, was paid.
i.e. 20/80 – insurer pays 20%/plan plays 80%.

Coordination of Benefits (COB)
A way to figure out who pays first when two or more health insurance plans are responsible for paying the same medical claim.

Copayment
A flat dollar amount you must pay for a covered program. Example: You may have a $25 copayment for each covered visit to a specialist (i.e. hematologist).

Deductible
The amount you must pay for covered medical services before your health insurance begins to pay. Insurers apply and structure deductibles differently. Example: Under one plan, a comprehensive deductible might apply to all services while another plan might have separate deductibles for benefits such as prescriptions drug coverage.

Deductibles for family plans may be embedded or non-embedded. Under an embedded deductible, each family member must meet his/her own deductible. Under non-embedded deductibles, the overall family deductible must be met before the plan begins to pay.

Dependent
A child or other individual for whom a parent, relative or other person may claim a personal exemption tax deduction. Under ACA, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.

Dependent Coverage
Insurance coverage for family members of the policyholder, such as spouse, children or partners. Under the ACA, all plans offering dependent coverage must cover dependents up to age 26, regardless of whether they are a tax dependent, live at home or are a student.

Diagnostic Test
Tests to help determine a specific health problem, e.g., X-ray, CT scan and ultrasound.

Donut Hole – Medicare Prescription Drug
Most plans with Medicare prescription drug coverage (Part D) have a coverage gap called a donut hole. This means that after you and your drug plan have spent a certain amount of money for covered drugs, you must pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends, and your drug plan helps pay for covered drugs again.

Drug (Formulary) List
A list of prescription drugs your insurance plan covers and may include how much you pay for each coved drug. The plan may categorize drugs into different groups with different copays, also known as tiers. Then the formulary will list drugs by these tiers. Formularies may include both generic drugs and brand-named drugs. The formulary may not include drugs that are administered under the major medical benefit of a plan. Also known as the preferred drug list (PDL).

Drug Utilization Review
An ongoing review of prescribing, dispensing and use of medication.

Employer-Sponsored Insurance (ESI)
This is health insurance provided by an employer who typically covers a portion of the costs. Sometimes called group health insurance. Plan options may include HMOs, PPOs and EPOs.

Exclusions
Items or services that are not covered under a contract for your insurance plan. The insurance company will not pay for these items or services.

Exclusive Provider Organization (EPO)
A managed care plan in which services are covered only if you go to doctors, specialists or hospitals in the plan's network (except in an emergency). EPOs are like HMOs except that individuals may not need a referral from a primary care provider to see a specialist.

Explanation of Benefits (EOB)
A form sent by an insurance company to the insured that includes a summary of the claims processed of the insured since their last claim. The EOB may also include a summary of what the insurer paid for the claim, what the insured's responsibility may be and a summary of the insured's year-to-date costs in the plan.

Fee for Service (FFS)
A reimbursement plan in which doctors and other healthcare providers are paid for services performed such as for tests and office visits.

Flexible Benefits Plan
Offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans and childcare. Although a common core of benefits may be required, you can choose how your remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes you can contribute more for additional coverage.

Flexible Spending Account (FSA)
Accounts offered and administered by employers that allow employees to set aside pre-tax dollars out of their paycheck to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Health Insurance Exchange (HIE)
Also known as Health Insurance Marketplace (HIM), these are new transparent and competitive health insurance plans. Individuals and small businesses can buy qualified health plans that meet certain benefit and cost standards. Every state has a Marketplace.

Health Insurance Portability and Accountability Act (HIPAA)
HIPPA is a 1996 law that eliminated discrimination by health insurers for those with a pre-existing medical condition. It also sets important privacy and security standards for health care entities so that consumers' health information is protected.

Health Maintenance Organization (HMO)
An insurance plan that usually limits coverage to care from providers who work for or contract with the HMP and will require you to obtain a referral from your primary care provider to be seen by a specialist. Typically, the HMO plans will not cover out-of-network services except in an emergent case and may require you to live or work in its service area to be eligible for coverage.

Health Saving Account (HSA)
A tax-exempt medical saving account that can be used to pay for current of future qualified medical expense. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. To open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan (HDHP). Unlike a Flexible Spending Account (FSA), funds roll over each year if funds are not spent.

Hemophilia Treatment Center (HTC)
A treatment facility comprised of a comprehensive, multidisciplinary team of medical professionals who specialize in providing care to individuals with hemophilia and other bleeding disorder diagnosis. Multidisciplinary team members can include hematologists, pediatricians, orthopedists, physical therapists, nurse coordinators, dentists, social workers and other healthcare professionals.

High Deductible Health Plan (HDHP)
A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more for medical services (your deductible) before the plan pays its portion.

In-Network Coinsurance
The percentage you pay of the allowed amount for the covered medical service to providers who contract with your insurance plan.

In-Network Copay
A fixed amount you pay for covered medical services to providers who contract with your insurance plan.

In-Network Provider
A list of providers (physicians, nurse practitioners, specialists, hospitals) who have contracts with your insurance plan.

Managed Care Organization
A group or organization that provides managed care plans.

Managed Care Plan
A plan that generally provides comprehensive health services to its members and offers financial incentives for patients to use the providers who belong to the plan, e.g., PPO, EPO and POS.

Maximum Out-of-Pocket (MOOP)
A yearly cap on the amount of money individuals are required to pay out-of-pocket for health-care costs, excluding the monthly premiums.

Medicaid
A state administered health insurance program that provides free or low-cost health coverage to some low-income people, families with children, pregnant women, the elderly and people with disabilities. The federal government provides a portion of the funding and sets guidelines. States also have choices in how they design their program causing Medicaid programs and eligibility to vary from state to state.

Open Enrollment Period (OEP)
The timeframe set to allow you to choose a new health insurance plan.

Out-of-Network Coinsurance
The percentage you pay of the allowed amount for covered medical services with providers who are not contracted with your health care plan which are higher costs than the in-network coinsurance.

Out-of-Network Copays
A fixed amount you pay for covered medical services from providers who are not contracted with your health care plan which are higher costs than the in-network providers.

Out-of-Network Providers
Providers who are not contracted with your healthcare plan.

Out-of-Pocket (OOP) Limit
The maximum amount you will be required to pay from covered services in a year. Once you have met your max, your insurance plans will cover all medical costs at 100%, excluding the cost of your monthly premiums.

Point-of-Service (POS) Plan
A type of plan in which you pay less if you use providers, hospitals and other healthcare professionals who belong to the plan's network. POS Plans may also require a referral from your primary care provider to see a specialist.

Preauthorization
Health insurance plans may require certain services, prescriptions and equipment authorization prior to receiving services. Also known as prior authorization, prior approval, or precertification.

Preferred Provider Organization (PPO)
Health insurance plans have contracts with certain participating providers and hospitals. If you chose to use providers outside of the contracted services, you will pay an additional cost.

Premium
A monthly or annual payment you make to your insurer to get and keep insurance coverage. Premiums can be paid by employers, unions, employees, individuals or shared among different payers.

Primary Care
Medical services provided that range from preventive, wellness and treatment options for general medical issues.

Primary Care Providers (PCP)
Physicians, nurse practitioners and physician assistants that provide care coordination to other medical specialties.

Self-insured Plan
The employer collects premiums from enrollees and take on the responsibility of paying employees' and dependents' medical claims. The employer contracts for insurance services such as enrollment, claims processing and provider networks with a 3rd party administrator. Self-insured plans do not follow state insurance rules. They are regulated under the federal rule known as ERISA and overseen by the US Department of Labor.

Summary of Benefits & Coverage (SBC)
The ACA requires plans to offer an overview of the plans benefits that is easy to understand and compare with other health insurance plans costs and coverage. SBCs can be obtained from your human resource representative, insurance agents, directly from insurance providers or the Marketplace.

Third Party Administrator (TPA)
An individual or firm hired by an employer to process claims, pay providers and manage other functions related to the operation of the health insurance plan.

RESOURCES

www.healthcare.gov/glossary/

www.hrsa.gov

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